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ABSTRACT

Group therapy is most effective when members step back and process the interaction among group members. This understanding of the group process is often referred to as self-monitoring or metacognition because it refers to a different level of thinking. All groups of people may not have equal metacognitive ability. This study examined the metacognitive ability of depressed persons. Subjects included nine individuals with a diagnosis of major depression in the experimental group and nine non-depressed individuals in the control group. Each subject watched a videotaped simulation of group therapy and commented on it. Each videotape consisted of four practice vignettes, an introduction to each of the group members, and 10 vignettes of interactions similar to those that occur in actual group therapy. One-half of the vignettes involved the subject as if he or she were a group member and the other half did not. A subject's memory of the vignettes was also tested. Results indicated that depressives were less capable than non-depressives of processing group interactions, despite comparable memory for content of the interactions. These results suggest that some subjects were unable to reflect on the interaction and that metacognitive and cognitive abilities are separate sets of skills. These results call into question the effectiveness of group therapy with depressives. (References are included.) (ABL)

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Group Therapy Processing as a Function of Depression

According to authorities in the field, group therapy is most effective when it does more than just provide interaction among group members. That is, when the members step back and "process" that interaction, they seem to get more out of the group.

Understanding the so-called "content" of group interaction requires the cognitive abilities of thinking and knowing. But understanding the "process" of the group may require another level of ability, such as being able to think about what one is thinking and know what one is feeling. This perspective is necessary in order to make comments such as, "During the group I was mad because I thought someone was trying to pull one over on me." It is not just getting mad, nor just thinking someone was trying to "pull one over on you ," but rather recognizing that is what you felt and what you thought.

This type of skill is often referred to as self-monitoring. Or, in a broader sense, because it requires a different, "meta" level of thinking, it is called "metacognition." It is sometimes asked whether metacognitive ability is not just another aspect of cognitive ability. The answer to this appears to be "no." There are differences on both a theoretical and on a practical level. The theoretical differences are summed up by Flavell (1979) when he said, "cognitive strategies are invoked to make cognitive progress, metacognitive strategies to monitor it." Also, it has been shown in our laboratory and others that cognitive abilities are not necessarily correlated with metacognitive abilities (Cavanaugh & Permutter, 1982; Gross, 1985; Slife et al, 1985) suggesting that they are not one and the same.

Metacognitive and self-monitoring skills seem to vary among groups of people. Snyder (1974) found that a heterogenous group he called "psychiatric ward patients" were "unable or unwilling to monitor" themselves. Related findings (Rahaim et al., 1980) with a more specific group showed that depressed individuals tend to be less able to monitor their own expressive behavior than are non-depressed individuals. Roth and Rehm (1980) showed that depressed patients were less accurate than normal controls in estimating how much negative and positive feedback they received. Slife, Marcoux, and Vlahos (1985) have found that depressed individuals had less "metaknowledge" of their cognitive performances in problem solving than normal controls.

From the above findings it appears that metacognitive ability is not equal in all populations. Most of the above work suggests that depressed individuals generally have a harder time than non-depressed individuals in monitoring themselves. This is interesting because it may be this same monitoring ability that is necessary in group therapy processing. Depression is among the most common symptoms of persons seeking mental health services, and thus is well-represented in group therapy populations. However, if depression is associated with a deficit in metacognitive skills, it may be that many of those participating in group therapy may be exactly those who are least able to make it work best. Group therapy may be less than optimally effective.

A deficit in processing ability, however, may lead to more than just less effective group therapy. The ability to "process," that is, the ability to step back and reflect on what is going on in an interpersonal situation, would be important in optimal social functioning. If one were lacking in

this skill, everyday interactions might not be always appropriate or functional because one might not "read" the interpersonal environment very well. This suggests that treatment of depressed individuals might want to address those patients' ability to process.

These two points, that group therapy might be more effective, and that metacognitive skill might be important in everyday social functioning, suggest that metacognitive is desirable. However, the effects of a deficit in metacognitive ability on group therapy per se have never been studied. This study proposes to address that very issue. Specifically, these authors propose to study the effects of depression on the ability to process group interactions.

As this particular test had never been done before, it was necessary to develop an instrument with which processing ability could be measured. Most assessment devices measure cognitive abilities, confound cognitive abilities with metacognitive abilities, or do not lend themselves to the context of the group. This study, then, also was conducted to test the procedure that was developed to measure group processing ability. The specific hypothesis put forth is that depressives are less capable than non-depressives of processing group interactions.

Method

Subjects

Nine individuals with a diagnosis of major depression served as the experimental group and nine matched non-depressed individuals served as the control. All of the depressed subjects scored 25 or higher on the Beck Depression Inventory (Beck et al.,1965), and the normals scored 3 or lower.

Structured (SADS) interviews (Endicott & Spitzer, 1978) were given to subjects, and research diagnostic criteria were applied. The subjects making up the experimental group were all inpatients at a general psychiatric facility. The controls were students and clerical staff from Baylor University.

Materials

Each subject watched a videotaped simulation of group therapy and was asked to comment on it. Each videotape consisted of four practice vignettes, an introduction to each of the group members, and 10 vignettes on which subjects were to make process comments. The simulations are 60-90 second vignettes of interactions similar to those that occur in actual group therapy. An example of such an interaction involves one member of the group that monopolizes the group's attention. Half of the vignettes involved the subject as if he or she were a group member, and half did not. The involvement was accomplished by posing a question to the camera, as if the subject were present in the group.

A subject's memory for the vignettes was also tested. One question was asked about each vignette, and tested only general knowledge about who acted in a particular way or who said what repeatedly.

Procedure

Each subject was administered the procedure individually in a quiet room. Diagnosis and interviews were conducted by persons other than the experimenters so that the experimenters, as well as the subjects, were "blind" as to their experimental condition. The four practice vignettes were used to make sure the subjects understood what was meant by "process comments," so they knew what was expected of them.

Subjects were then shown the 10 vignettes. After each one, the tape was stopped and they were given a "process check" (Yalom, 1975), by being asked "What's going on in the group?" At the end of all the vignettes and comments the memory task was administered.

Rating of Subject Comments

All tape recordings of subject comments were rated for level of processing by two judges who were "blind" to the subjects' conditions. The judges used a five point Likert scale to rate the comments at a .80 (or higher) level of reliability, using Cohen's (1960) Kappa. The criteria that determines the ratings included the extent to which the comments a) explained the "why" of the interaction, b) attended to the "here and now" of the interaction and, c) focused on the relationships involved in the interaction. These scores were combined to form a total score. The comments were also rated in a similar manner as to proximity to an "expert view" of the process. This rating was separate so that the quality, or the style, of the response could be distinguished from the accuracy of the content.

Results

The two dependent measures were the "quality" of the comments and the "accuracy" of the comments. The independent variables were diagnosis (major depression, non-depressed) and type of vignette (involvement, non-involvement). A covariate was the memory task score. A 2x2 multivariate analysis of covariance was performed.

There was a significant main effect for diagnosis. That is, as predicted, the ratings of the major depressed group's comments were

significantly lower for both quality and accuracy than the non-depressed group's. The vignette and interaction effects were not significant.

Discussion

The results support the hypothesis that depressives are less capable than non-depressives of processing group interactions. This was despite comparable memory for the content of the interactions. So it does not mean the subjects did not retain or comprehend what had happened, rather it suggests that they were unable to step back and reflect on that interaction. This supports previous research indicating that metacognitive and cognitive abilities are separate sets of skills. These results also question whether therapies that rely upon processing, such as group therapy, can be effectively conducted with major depressives.

There are limitations to this study, however, and many of these are currently being addressed in a more extensive follow-up study. Two factors that were not controlled could be confounding the results. First, verbal ability may have affected the comments. Depressives may have been less able to express what they saw going on even if they understood it. Second, the realism of the simulations may have differed between the two groups of subjects. The depressed group was more likely to have experienced actual group therapy, and so prehaps would have felt less involved if the vignettes were not close to what actually happens. Finally, there was a limited sample size involved, and low methodological power. The current study addresses these factors by increasing the sample size, and using measures of verbal ability and of realism.

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